Suicide Among Montana's American Indians

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Suicide Fact Sheet

Center for Disease Control – WISQARS website, http://www.cdc.gov/injury/wisqars/index.html, (January, 2016)

- Suicide has **surpassed car accidents** as the No. 1 cause of injury-related death in the United States. There has been a **28% increase** in the number of suicides in the United States since 2001 (CDC, 2013)
- In 2014 there were **42,773** suicides in the U.S. (**117** suicides per day; 1 suicide every **12** minutes). This translates to an annual suicide rate of **13.4 per 100,000**.
- Males complete suicide at a rate **four times** that of females. However, females attempt suicide **three times** more often than males.
- Firearms remain the most commonly used suicide method, accounting for nearly **50%** of all completed suicides.

Suicide and Primary Care

- Up to **45%** of individuals who die by suicide visit their primary care provider within **a month** of their death, with **20%** of those having visited their primary care provider within **24 hours** of their death
- In a 2014 Washington state study, out of 100 people seen in a ED who attempted suicide, **83** were seen by their PCP in the past month. Only **55** were asked about suicide by the PCP.

Suicide among Children

- In 2014, **428** children ages 5 to 14 completed suicide in the U.S. (up from 395 in 2013 and 311 in 2012)
- Suicide rates for those between the ages of 5-14 **increased 60%** between 1981 and 2010.

Suicide among the Young

- Suicide is the **2nd leading cause of death** among young (15-24) Americans; only accidents occur more frequently. In 2014, there were **5,079** suicides by people 15-24 years old. (up from 4,878 in 2013)
- Youth (ages 15-24) suicide rates increased more than **200%** from the 1950's to the mid 1990's. The rates dropped in the 1990's but went up again in the early 2000's.

- Research has shown that most adolescent suicides occur after school hours and in the teen's home.
- Within a typical high school classroom, it is likely that **three students** (one boy and two girls) have made a suicide attempt in the past year.
- *Most* adolescent suicide attempts are precipitated by **interpersonal conflicts**. The intent of the behavior appears to be to effect change in the behaviors or attitudes of others.

Suicide among our Veterans

Veteran Suicide Statistics, 2014

- An average of **20** Veterans died from suicide each day. **6 of the 20 were users of VA services (30%).**
- Veterans accounted for **18%** of all deaths from suicide among U.S. adults, while Veterans constituted 8.5% of the US population.
- Approximately **66%** of all Veteran deaths from suicide were the result of **firearms**.
- Approximately **65%** of all Veterans who died from suicide were aged **50 years or older.**
- After adjusting for differences in age and gender, risk for suicide was **21% higher among Veterans when compared to U.S. civilian adults.**

Source: Thompson, C (July, 2016). Veterans Administration. 2014 VA Suicide Prevention Program: Facts about Veteran Suicide.

Suicide among College Students

- It is estimated that there are more than **1,100 suicides** on college campuses per year, making it the **2nd leading cause of death** for college students.
- 1 in 12 college students have made a suicide plan.
- 9.5% of students had seriously contemplated suicide.
- An estimated **24,000 suicide attempts** occur annually among US college students aged 18-24 years.

Suicide among the Elderly

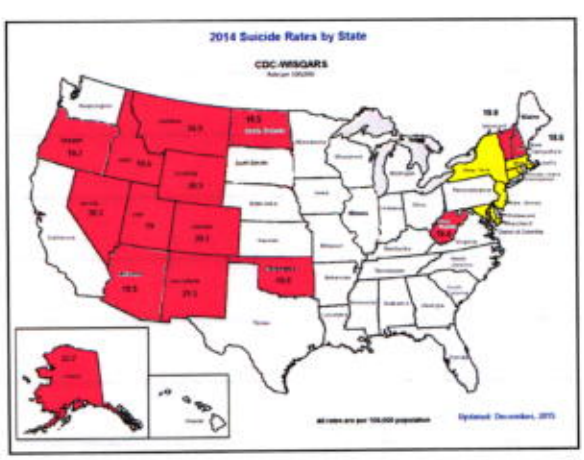
- In 2014, **7,693** Americans over the age of 65 died by suicide for a rate of **16.64** per 100,000 people
- The rate of suicide for women typically stabilizes after age 64 (after peaking in middle adulthood, ages 50-54) .
- 85% of elderly suicides were male; the rate of male suicides in late life was **7 times** greater than for female suicides.

- White men over the age of 85, who are labeled "old-old", were at the greatest risk of all age-gender-race groups. In 2014, the suicide rate for these men was **54.4** per 100,000.
- Elders who complete suicide:
  - **73%** have contact with primary care physician within a **month** of their suicide, with **nearly half** visiting in the preceding week.
- There is a strong correlation between chronic pain and suicide
  - **20-30%** of those who die by suicide have issues of chronic illness or pain.
  - A person with chronic pain is **3 times** the risk of suicide

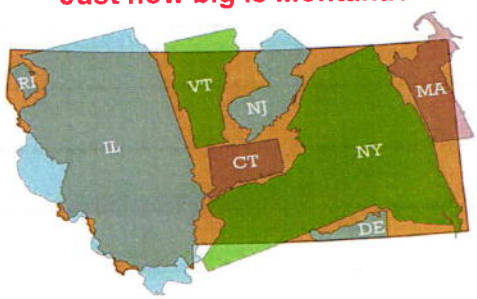
Suicide in Montana

Data Source: CDC-WISQARS (12/23/15)

- For all age groups, Montana has ranked in the **top five** for suicide rates in the nation, for the past forty years.
- According to the most recent numbers released by the National Vital Statistics Report for **2014**, **Montana has the highest rate of suicide in the United States (251 suicides for a rate of 24.52).**



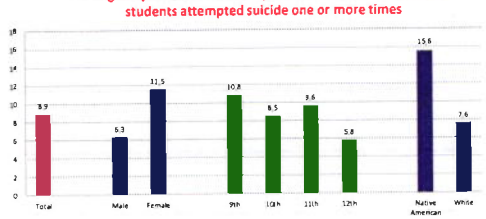
Just how big is Montana?



Population of 9 east coast states – 50 million,
Population of Montana – 1 million

2015 YRBS Data - Suicide

During the past 12 months, 8.9 percent of Montana high school students attempted suicide one or more times



2015 YRBS Data - Suicide

Montana high school students who had attempted suicide are ***more likely*** than those students who had not attempted suicide to have:

- Drove when **drinking alcohol during the past 30 days** (27% of students who attempted suicide compared to 9% of students who had not attempted suicide).
- Ever been **physically forced to have sexual intercourse** when they did not want to (32% of students who attempted suicide compared to 6% of students who had not attempted suicide).
- Been **bullied on school property** during the past 12 months (55% of students who attempted suicide compared to 23% of students who had not attempted suicide).

2015 YRBS Data - Suicide

Montana high school students who had attempted suicide are ***more likely*** than those students who had not attempted suicide to have:

- Been **electronically bullied** during the past 12 months (49% of students who attempted suicide compared to 16% of students who had not attempted suicide).
- Smoked a **cigarette** during the past 30 days (35% of students who attempted suicide compared to 11% of students who had not attempted suicide).
- Used **marijuana** during the past 30 days (42% of students who attempted suicide compared to 17% of students who had not attempted suicide).

Suicides among American Indians, US vs MT

(Based on the CDC's WISQARS)

2005 - 2014, United States
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Both Sexes, All Ages
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
4,440	41,165,530	10.79	10.63

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Both Sexes, All Ages
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
188	689,001	27.29	28.16

Suicides among American Indians by Race

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, All Ages
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
2,199	9,848,579	22.33	21.70

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
White, Both Sexes, All Ages
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
1,990	9,001,143	22.11	21.07

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Both Sexes, All Ages
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
188	689,001	27.29	28.16

Suicides among American Indians by Gender

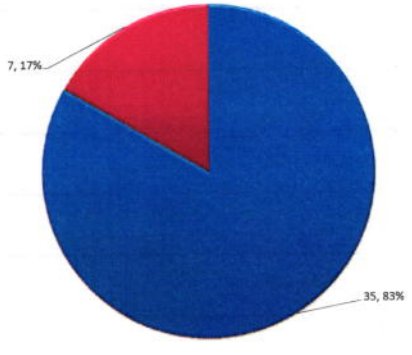
2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Females, All Ages
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
50	347,454	14.39	14.17

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Males, All Ages
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
138	341,547	40.40	43.28

Gender of American Indian Suicides in Montana



Suicide among American Indians, ages 11-24

2005 - 2014, United States
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 11 to 24
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
48,186	601,605,595	8.01

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
White, Both Sexes, Ages 11 to 24
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
246	1,654,999	14.86

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Both Sexes, Ages 11 to 24
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
76	177,489	42.82

Suicide among American Indians, ages 25-85+

2005 - 2014, United States
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 25 to 85+
ICD-10 Codes: X60-X84, Y87.0,*U03

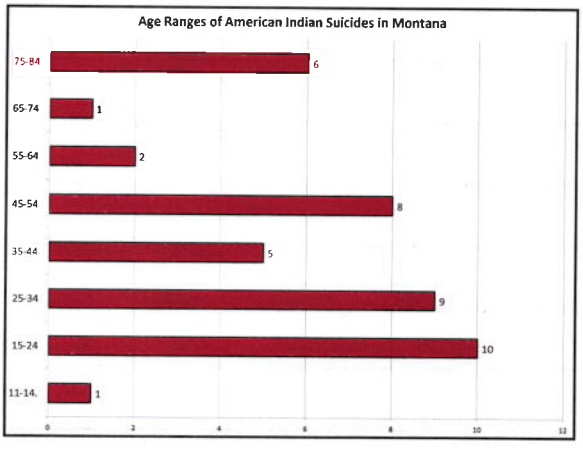
Number of Deaths	Population***	Crude Rate
327,495	2,031,643,994	16.12

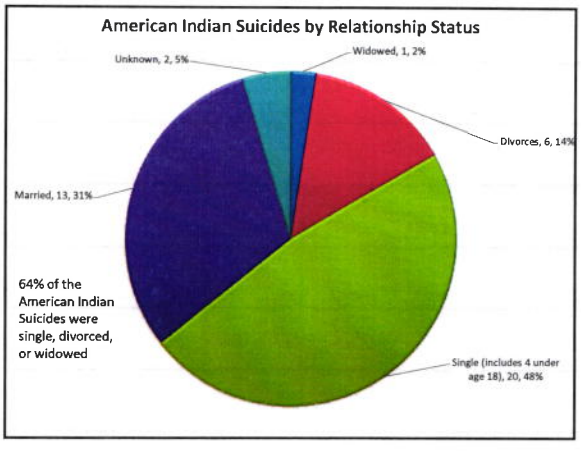
2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 25 to 85+
ICD-10 Codes: X60-X84, Y87.0,*U03

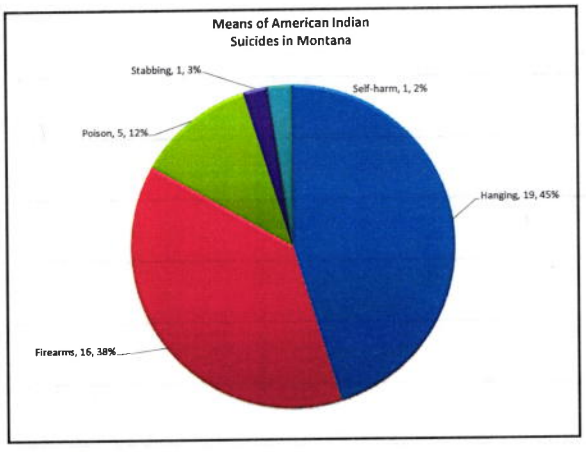
Number of Deaths	Population***	Crude Rate
1,872	6,635,897	28.21

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Both Sexes, Ages 25 to 85+
ICD-10 Codes: X60-X84, Y87.0,*U03

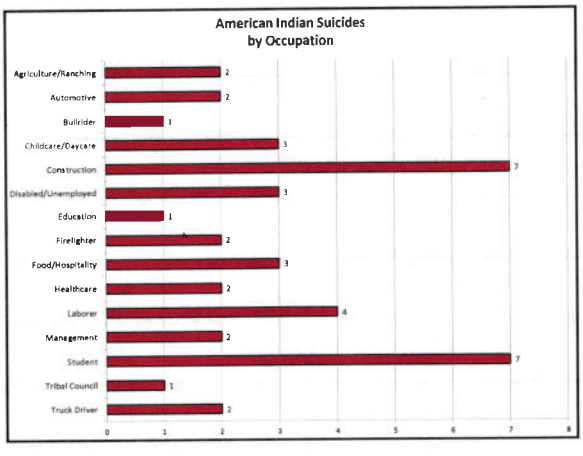
Number of Deaths	Population***	Crude Rate
112	350,016	32.00






Means of American Indian Suicides in Montana
Stabbing, 1, 3%
Self-harm, 1, 2%
Poison, 5, 12%
Hanging, 19, 45%
Firearms, 16, 38%


Educational Level of American Indian Suicides in Montana
8th or less
9th-12th
High School Diploma
Some College
Associates Degree
Master's Degree
3
9
16
8
5
1
0
2
4
6
8
10
12
14
16
18
67% of the American Indian suicides in Montana had a high school education or less.


American Indian Suicides by Occupation
Agriculture/Ranching
Automotive
Bullrider
Childcare/Daycare
Construction
Disabled/Unemployed
Education
Firefighter
Food/Hospitality
Healthcare
Laborer
Management
Student
Tribal Council
Truck Driver
2
2
1
3
7
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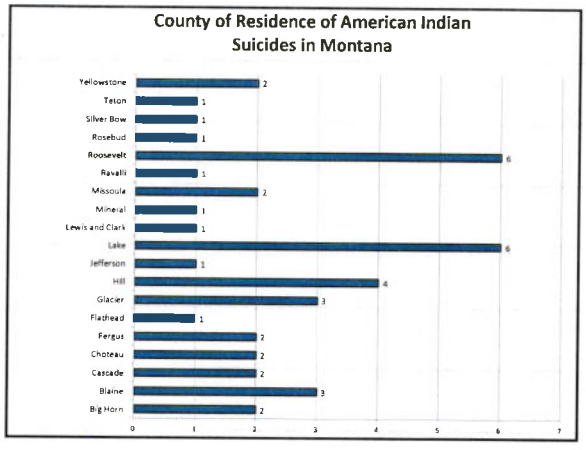
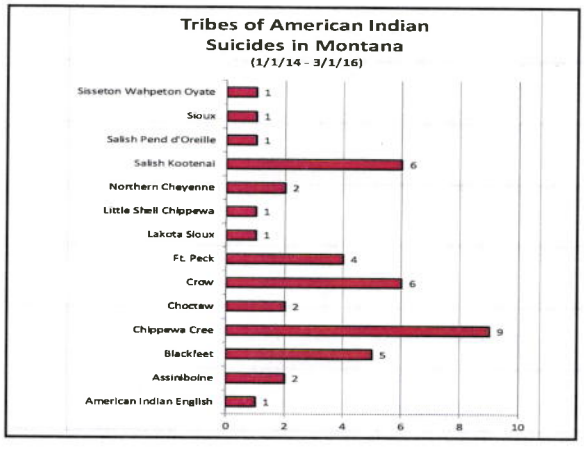
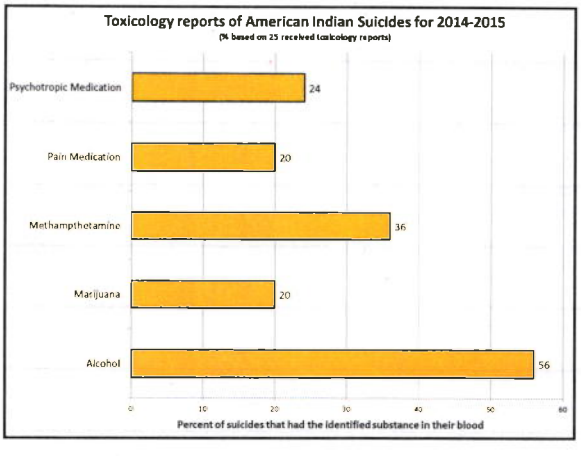
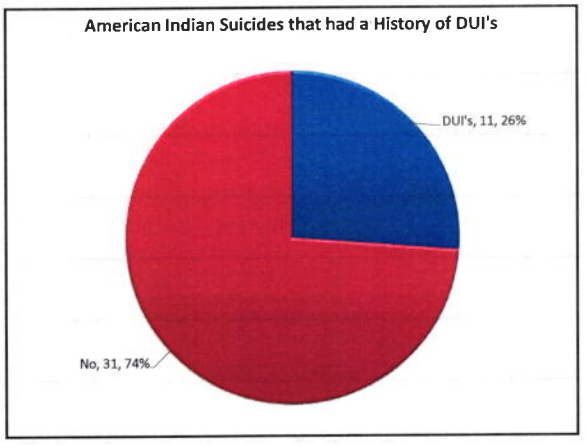
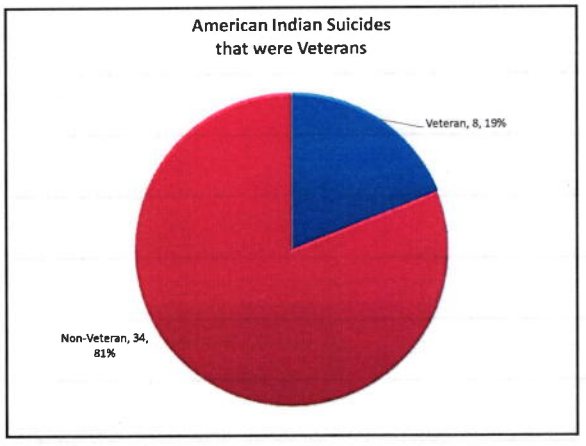
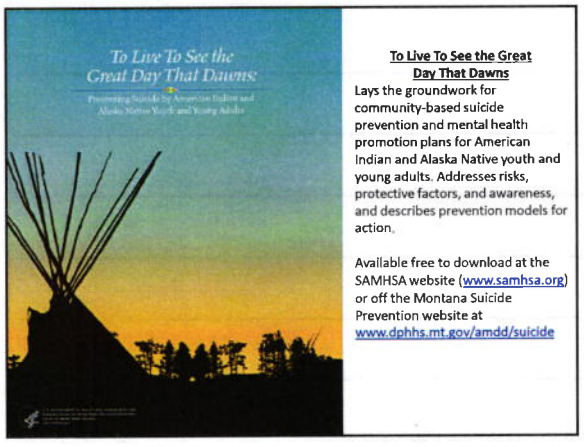

County of Residence of American Indian Suicides in Montana
Yellowstone 2
Teton 1
Silver Bow 1
Rosebud 1
Roosevelt 6
Ravalli 1
Missoula 2
Mineral 1
Lewis and Clark 1
Lake 6
Jefferson 1
Hill 4
Glacier 3
Flathead 1
Fergus 2
Choteau 2
Cascade 2
Blaine 3
Big Horn 2
0 1 2 3 4 5 6 7


Tribes of American Indian Suicides in Montana
(1/1/14 - 3/1/16)
Sisseton Wahpeton Oyate 1
Sioux 1
Salish Pend d'Oreille 1
Salish Kootenai 6
Northern Cheyenne 2
Little Shell Chippewa 1
Lakota Sioux 1
Ft. Peck 4
Crow 6
Choctaw 2
Chippewa Cree 9
Blackfeet 5
Assiniboine 2
American Indian English 1
0 2 4 6 8 10


Toxicology reports of American Indian Suicides for 2014-2015
(% based on 25 received toxicology reports)
Psychotropic Medication 24
Pain Medication 20
Methampthetamine 36
Marijuana 20
Alcohol 56
0 10 20 30 40 50 60
Percent of suicides that had the identified substance in their blood





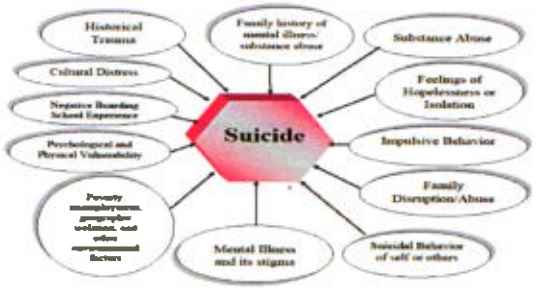


To Live To See the Great Day That Dawns

Lays the groundwork for community-based suicide prevention and mental health promotion plans for American Indian and Alaska Native youth and young adults. Addresses risks, protective factors, and awareness, and describes prevention models for action.

Available free to download at the SAMHSA website (www.samhsa.org) or off the Montana Suicide Prevention website at www.dphhs.mt.gov/amdd/suicide

Interrelated Risk Factors for Suicide Among American Indian Youth



Changeable Risk Factors

- Changeable risk factors include; substance abuse, exposure to bullying and violence, and development of resiliency and problem-solving skills.
- Factors that cannot be changed include age, gender, and genetics. **While a community cannot change any of these factors, its members can be aware of the increased risk for suicide that these factors present**.

Understanding the role of Historical Trauma

- Historical trauma includes forced relocations, the removal of children who were sent to boarding schools, the prohibition of the practice of language and cultural traditions, and the outlawing of traditional religious practices. Today's American Indian youth are experiencing a new type of historical trauma in the form of poverty, substance abuse, violence, loss of language and disconnect from their culture.

Understanding the role of Historical Trauma

- What is important to understand is that although most young American Indians did not experience the historical trauma that their ancestors did, generational changes to the family system were caused that effect how families function. It is estimated that it takes 7 generations for the historical trauma to get to where it is today and will take 7 generations to fix it.

Understanding the role of Historical Trauma

- Historical trauma may also have an effect on the help-seeking behavior of American Indian youth. They may believe these services represent the "white man's" system and culture or that the professional will not understand Native ways. Not only do a majority of American Indians use traditional healing, they rate their healer's advice more than 60% higher than their physician's advice.

Understanding the role of Historical Trauma

- It is also important to remember the survivors of suicide. Research has indicated that for every suicide, there are 6 direct survivors. This is even more prominent in the American Indian community, where the direct survivors may be 25 or even the entire community. What is vital to know is that a survivor of suicide is three times the risk of completing suicide themselves.

Protective Factors

Protective Factors

- The most significant protective factors against suicide attempts among American Indian youth are the opportunity to discuss problems with family or friends, feelings connected to their family, and positive emotional health.

Protective Factors

- When a suicide has occurred, the possibility of suicide contagion is decreased by a healing process that involves the role of Elders and youth in decision-making, the presence of adult role models, and the use of traditional healing practices.

Approximately 90% of those who complete suicide suffer from at least one major psychiatric disorder

- Depressive disorders are consistently the most prevalent disorder (49-64%)
- The 2nd most frequent diagnosis is a Substance abuse disorder.
- Approximately 1/3 of male suicides have had a conduct disorder, often co-morbid with a mood, anxiety, or substance abuse disorder.

Depression is Treatable

Depression is the most treatable of all psychiatric disorders in young people

- 86% treatment rate with a combination of antidepressants and therapy*
- Only 40-70% with either by themselves.

* Source: The TADS Team. The Treatment for Adolescents with Depression Study (TADS): Long-term Effectiveness and Safety Outcomes. Archives of General Psychiatry. Oct 2007; VOL 64(10).

What can be done at the Community Level

- Each community is individual and must look within their own culture and traditions for the strength and wisdom to change.

What can be done at the Community Level

- Ask the community Elders how community members have traditionally come together to address issues and what are the stories that have motivated members to address issues in the past. Many of the stories told by the Elders hold the values of what once was and the vision of what ought to be and can be for a Tribe or Village. Thus, when a community views the behavior of its young and finds it at odds with the values of these stories, the seeds of change are planted.

What can be done at the Community Level

- Underlying all of the barriers to the suicide conversation is language. The concept of suicide as "honorable" needs to be acknowledged within its historical context and then reassessed and confronted.

What can be done at the Community Level

- The pain experienced by those who have lost loved ones to suicide is another barrier to having an open and public conversation about suicide. With this barrier in mind, it is appropriate that the person wishing to hold a suicide conversation within the community should first ask permission to bring up the topic and ask forgiveness for causing them pain.

What can be done at the Community Level

- American Indian community prevention plans need to include community-based ceremonies and traditions to begin the healing of the collective grief. This is different and individual for each community.

What can be done at the Community Level

Encourage Tribal and Elder involvement in;

- schools
- police and fire service
- health care delivery
- using indigenous language
- promoting spiritual beliefs

QPR

Ask A Question, Save A Life

QPR

Question, Persuade, Refer

QPR

- QPR is <u>not</u> intended to be a form of counseling or treatment.
- QPR <u>is</u> intended to offer hope through positive action.

QPR

Suicide Myths and Facts

- **Myth** No one can stop a suicide, it is inevitable.
- **Fact** If people in a crisis get the help they need, they will probably never be suicidal again.
- **Myth** Confronting a person about suicide will only make them angry and increase the risk of suicide.
- **Fact** Asking someone directly about suicidal intent lowers anxiety, opens up communication and lowers the risk of an impulsive act.

QPR

Suicide Myths and Facts

- **Myth** Only experts can prevent suicide.
- **Fact** Suicide prevention is everybody's business, and anyone can help prevent the tragedy of suicide
- **Myth** Suicidal people keep their plans to themselves.
- **Fact** Most suicidal people communicate their intent sometime during the week preceding their attempt.

QPR

Myths And Facts About Suicide

- **Myth** Those who talk about suicide don't do it.
- **Fact** People who talk about suicide may try, or even complete, an act of self-destruction.
- **Myth** Once a person decides to complete suicide, there is nothing anyone can do to stop them.
- **Fact** Suicide is the most preventable kind of death, and almost any positive action may save a life.

How can I help? Ask the Question...

QPR

Suicide Clues And Warning Signs

The more clues and signs observed, the greater the risk. Take all signs seriously!

QPR

Direct Verbal Clues:

- "I've decided to kill myself."
- "I wish I were dead."
- "I'm going to commit suicide."
- "I'm going to end it all."
- "If (such and such) doesn't happen, I'll kill myself."

QPR

Indirect Verbal Clues:

- "I'm tired of life, I just can't go on."
- "My family would be better off without me."
- "Who cares if I'm dead anyway."
- "I just want out."
- "I won't be around much longer."
- "Pretty soon you won't have to worry about me."

QPR

Behavioral Clues:

- Any previous suicide attempt
- Acquiring a gun or stockpiling pills
- Co-occurring depression, moodiness, hopelessness
- Putting personal affairs in order
- Giving away prized possessions
- Sudden interest or disinterest in religion
- Drug or alcohol abuse, or relapse after a period of recovery
- Unexplained anger, aggression and irritability

QPR

Situational Clues:

- Being fired or being expelled from school
- A recent unwanted move
- Loss of any major relationship
- Death of a spouse, child, or best friend, especially if by suicide
- Diagnosis of a serious or terminal illness
- Sudden unexpected loss of freedom/fear of punishment
- Anticipated loss of financial security
- Loss of a cherished therapist, counselor, teacher, or pet
- Fear of becoming a burden to others

QPR

Tips for Asking the Suicide Question

- If in doubt, don't wait, ask the question
- If the person is reluctant, be **persistent**
- Talk to the person alone in a private setting
- Allow the person to talk freely
- Give yourself plenty of time
- Have your resources handy; QPR Card, phone numbers, counselor's name and any other information that might help

Remember: How you ask the question is less important than that you ask it

Q *QUESTION*

Less Direct Approach:

- "Have you been unhappy lately? "
- "Have you been very unhappy lately?"
- "Have you been so very unhappy lately that you've been thinking about ending your life?"
- "Do you ever wish you could go to sleep and never wake up?"

Q *QUESTION*

Direct Approach:

- "You know, when people are as upset as you seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way, too?"
- "You look pretty miserable, I wonder if you're thinking about suicide?"
- "Are you thinking about killing yourself?"

NOTE: If you cannot ask the question, find someone who can.

How not to ask the suicide question

"You're not suicidal, are you?"

P *PERSUADE*

HOW TO PERSUADE SOMEONE TO STAY ALIVE

- Listen to the problem and give them your full attention
- Remember, suicide is not the problem, only the solution to a perceived insoluble problem
- Do not rush to judgment
- Offer hope in any form

P *PERSUADE*

Then Ask:

- "Will you go with me to get help?"
- "Will you let me help you get help?"
- "Will you promise me not to kill yourself until we've found some help?"

YOUR WILLINGNESS TO LISTEN AND TO HELP CAN REKINDLE HOPE, AND MAKE ALL THE DIFFERENCE.

R *REFER*

- Suicidal people often believe they cannot be helped, so you may have to do more.
- The best referral involves taking the person directly to someone who can help.
- The next best referral is getting a commitment from them to accept help, then making the arrangements to get that help.
- The third best referral is to give referral information and try to get a good faith commitment not to complete or attempt suicide. Any willingness to accept help at some time, even if in the future, is a good outcome.

REMEMBER

Since almost all efforts to persuade someone to live instead of attempt suicide will be met with agreement and relief, don't hesitate to get involved or take the lead.

For Effective QPR

- Say: "I want you to live," or "I'm on your side...we'll get through this."
- Get Others Involved. Ask the person who else might help. Family? Friends? Brothers? Sisters? Pastors? Priest? Rabbi? Bishop? Physician?

For Effective QPR

- Join a Team. Offer to work with clergy, therapists, psychiatrists or whomever is going to provide the counseling or treatment.
- Follow up with a visit, a phone call or a card, and in whatever way feels comfortable to you, let the person know you care about what happens to them. Caring may save a life.

REMEMBER

WHEN YOU APPLY QPR, YOU PLANT THE SEEDS OF HOPE. HOPE HELPS PREVENT SUICIDE.

Other Evidenced-Based Suicide Prevention Programs

QPR

A two-hour gatekeeper training that raises awareness of warning signs and how to intervene with a person at risk.

Other Evidenced-Based Suicide Prevention Programs

ASIST

A two-day workshop designed to provide participants with gatekeeping knowledge and skills. Gatekeepers are taught to recognize the warning signs and to intervene with appropriate assistance.

Other Evidenced-Based Suicide Prevention Programs

SOS: Signs of Suicide

School-based program which aims to raise awareness of suicide and reduce stigma of depression There is also a brief screening for depression and other factors associated with suicidal behavior.

Other Evidenced-Based Suicide Prevention Programs

Parents As Partners: A suicide prevention guide for parents

Educates parents about depression and its link to suicide. Raises awareness and identifies warning signs. Informs parents about resources. Go to www.save.org for additional information.

Other Evidenced-Based Suicide Prevention Programs

Crisis Intervention Training

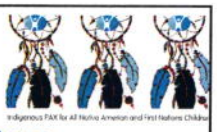
CIT came out of the Memphis Police Dept. and is a training for law enforcement officers to help them manage mental health issues when they respond to a call.

Other Resource

Suicide Prevention Toolkit for Rural Primary Care Physicians

Suicide assessment and intervention kit designed for physicians practicing in rural communities.

Possible early age intervention



PAX Indigenous Good Behavior Game

For our children to grow up to live a good life, they must develop the skills and abilities to not abuse tobacco, alcohol and other drugs, to not engage in delinquent and criminal behaviors, have fewer mental, emotional and behavioral disorders, not to have suicidal ideation or even worse, take their own lives. They need to develop the social skills and competencies on the reservations and in the cities. They must have the ability to self-monitor and self-regulate their behaviors, and switch courses effectively when required. The PAX Good Behavior Game® is a universal prevention program that has been researched for over 30 years and has been shown to improve the outcomes for children who have received the intervention in urban, rural and tribal communities.

Depression is Treatable
Suicide is Preventable

If you are in crisis and want help, call the Montana Suicide Prevention Lifeline at 1-800-273-TALK **(1-800-273-8255)** Or text "MT" to 741 741

www.dphhs.mt.gov/amdd/suicide